

DDS Guidelines for Periodic Reviews of Do Not Resuscitate Orders

1. Once a DNR is implemented, the code status change must be documented on the Individual Plan (IP). This should be documented in the IP.2 Health and Wellness section.
 - a. The Code Status will need to be reviewed by the team as part of the IP process.
 - b. A DDS “DNR Review Documentation” form will need to be completed quarterly for all individuals.

2. It is the responsibility of the team nurse to complete the “DNR Review Documentation” form. For consumers residing permanently in Long Term Care facilities, the case manager shall retain the responsibility for completing this form. For residents of Southbury Training School (STS) the Primary Medical Care Practitioner will complete the form.
 - a. If the review finds the individual still meets the DDS criteria for a DNR Order:
 - i. The date is entered in the date column, the Medical Condition Column would be checked “unchanged”, in the Action Taken column the subheading “date DNR was”, the “continued” box would be filled in and the person completing the document would sign in the signature box.
 - b. If the review finds the individual no longer meets the DDS criteria for a DNR Order:
 - i. The date is entered in the date column, the Medical Condition Column would be checked “changed”, the Action Taken column would indicate who the team has referred the matter to (e.g. guardian, physician, etc.) and the person completing the document would sign in the signature box.
 - ii. If the physician and guardian are in agreement that the DNR should be removed, the discontinued date box should be completed and the person completing the document would sign in the signature box.
 - iii. If the physician and guardian are in agreement that the DNR should still be continued, the team should refer the matter to the Regional Health Service Director for follow up.

3. The completed “DNR Review Documentation” form should be maintained with the individual’s records. Team nurse will keep original in individual medical record. A copy of the document shall be sent to the Regional Health Service Director within two (2) weeks after each review. For reviews done by case managers the original documentation will be kept in the case management master record and a copy of the document shall be sent to the Regional Health Service Director within two (2) weeks after each review. This document will also be requested as part of the Mortality Review documentation. At STS the review forms will be kept in the individual medical record and the Medical Director or designee will update and distribute a monthly list with current review dates.